Narcotic Addiction

Medical and Legal Problems with Physicians

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THE NUMBER OF narcotic addicts in this country is probably not much greater now than half a century ago, although wider press and radio coverage dramatizes the situation. Before the Harrison Narcotic Act it was estimated that there was one addict per four hundred population, whereas the present estimate is one in three thousand. As long as there are unstable people there will be narcotic addicts, and the objective is to reduce the number to an irreducible minimum. The situation is serious, however, and particularly so to the family, friends and colleagues of the addicted person.

Almost twelve years' experience as a member of the California State Board of Medical Examiners leaves me with restrained optimism about the control of narcotic addiction in physicians. At first, there was a feeling of shock in finding addiction among friends whose ability and integrity I had admired over the years. I felt, naively as it turned out, that since they were intelligent men, it would be simple to talk to them about the problem, and convince them of the desirability of doing something about it. They appeared grateful for my interest and my sincere desire to help them, and were anxious to avoid the publicity of eventual conviction, but no good came of it, as their promises meant nothing even though their intentions were good: the habit was much stronger than they were and they continued to divert narcotics to their own use.

Certain published articles imply a tremendously higher rate of addiction in physicians than in the general population, and while this is to a certain extent true, the figures are misleading, for they are based on admissions to hospitals for the treatment of addiction, and represent evidence of the fact that the physician addict will commit himself to an institution in an effort to be cured, whereas most addicts enjoy being addicted and do not at all desire to be cured. Material compiled by Doctor Louis Jones and Mr. Wallace Thompson of the California State Board of Medical Examiners reveals a remarkably high rehabilitation rate—92 per cent—in physician narcotic addicts compared with optimistic figures of possibly 5 per cent in nonphysician addicts. This involves a five to ten-year follow-up of 130 physician addicts.

The California Board, which licenses some 2,000 physicians a year, annually considers about 50 cases of narcotic violations involving physicians. If the violation involves actual peddling of narcotics to addicts, outright revocation of the license to practice medicine is the usual penalty. The exception is made at times for the senile physician who becomes victimized by addicts who can support themselves and sustain their addiction by selling the narcotics he prescribes. The usual device is for them to give a story that their wife has migraine, dysmenorrhea or the like, and the doctor naively prescribes the narcotics. The effective management of a senile physician is to revoke his license to practice medicine but put a stay of execution on the revocation and place him on indefinite probation, one of the terms of the probation being that he be indefinitely prohibited from prescribing narcotics or having them in his possession.

If a physician is addicted and has been in an institution or in jail, or has had no narcotics available to him for a reasonable length of time, then the approach of the Board is one of rehabilitation. It has been our experience that rehabilitation is facilitated by allowing a doctor to practice medicine, but withholding narcotic privileges from him for a period of five years. A penalty is set up in this way: His license to practice medicine is revoked, but there is a stay of execution on the revocation of his license and he is placed on probation for five years. The terms of his probation may vary, but he reports frequently to the Board members, and the important provision is that he surrenders his narcotics stamp and does not prescribe narcotics nor have them in his possession during the five-year period. Interestingly, this does not make for much hardship, as his hospitalized patients can have their narcotics ordered by an anesthetist or a colleague. The penalty of outright revocation of his right to practice hanging over him is very effective. Many times, doctors have said to me that they felt we were harsh and lacked understanding and compassion when we didn't take their word for it that they understood their problem and would not return to the use of narcotics. Invariably, however, they would later

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state that once or twice or three times during the five-year period when the going was rough and they couldn't sleep, if they had had narcotics available, they would have said, "Well, just for tonight I'll tide myself over," and then would have been addicted again.

They are seen by members of the Board at various intervals, and it is pointed out to them that we want them to stay on the team and that 92 per cent of their colleagues have licked the addiction habit and we feel that they can lick it, too. It is also pointed out rather bluntly that their choice is not very wide since the 8 per cent who return to addiction usually kill themselves.

Medicine is not just a way of earning a living to most doctors—it is a way of life, and the doctor enjoys the affection of his patients, the feeling of triumph when he sees them get well, and the general aura that his work is appreciated. When this is denied to him by outright revocation of his license to practice, it is analogous to placing the average addict on the rock pile, or building roads on the desert. There might be a practical application herein where the average addict could be placed on the rock pile with a sort of indefinite probation, and be released when he showed evidence of rehabilitation, but be returned should he again use narcotics. In any event, the practical effect here, as far as the physician addict is concerned, is a very neat arrangement of the doctrine of the fear of punishment and the hope of reward.

Unhappily, very few physician addicts will break the habit on their own, and the club is necessary. The physician addict originally assumes that he can quit the habit any time he wants to, and that it is a little like alcohol which most people can either take or leave alone. It takes him a long time to realize that, once addicted, he is no different from any stumble-bum on skid row and, in a sense, has to be treated accordingly.

THE "AGONIES" OF WITHDRAWAL

There is a good deal of malarkey about the agonies of withdrawal, as physician addicts have invariably stated that physical dependence on narcotics is gone after a rather rough 72-hours or so. The mental need and the feeling that it would be nice to have narcotics, of course, never leave the addict and he must face this all his life. The length of time a man is addicted apparently doesn't have much bearing on the situation, as I well remember one physician addict of some eighteen years who traveled widely and was usually able to purchase narcotics. He was tremendously overweight, and had chronic phlebitis with leg pains which he felt justified the narcotics. When his physician friends refused to write prescriptions for his leg pains, he forged prescriptions and was apprehended. Since he had made no effort at rehabilitation, his license to practice medicine was revoked outright. He was highly indignant, pointing out that he had been taking narcotics for some eighteen years, and that the phlebitis and the pains in his legs were so severe that he had to have narcotics every four hours. When he did have them, he said, he could function reasonably well in his practice of internal medicine. We pointed out that we did not feel morphine every few hours indefinitely was good treatment for phlebitis, and he left the hearing room quite bitter. He subsequently appeared to petition for restoration of his license, and was a changed man. He had lost a good deal of weight and had not taken narcotics for a year. He stated frankly that to his astonishment, we had done him a great favor. "You know," he said, "I really was addicted and just wouldn't face up to it, but used my phlebitis as a crutch to rationalize my addiction." Interestingly, he said the pains in his legs had lessened to such a degree that they could be controlled with aspirin. His license to practice was restored but narcotic privileges were withheld for a period of five years. As a matter of fact, he stated he never wanted a narcotic license again, as he did not want to have any access to narcotics.

The narcotic addiction danger to physicians is not brought to the attention of medical students. As a result of my experiences on the Board, panel discussions on the subject were initiated about nine years ago at the College of Medical Evangelists. The representatives included law enforcement officers, Board members, psychiatrists, pastors and others interested in the subject. Partly, I hope, as a result of this, only one physician addict has turned up who has been exposed to these discussions.

The idea of establishing clinics for narcotic addicts, where the addict could be furnished narcotics cheaply, has intrigued many well-meaning people. The thought is that if the profit motive were taken away the peddler would disappear and there would be a better chance for rehabilitation. This seems a bit like second marriage; namely, evidence of the triumph of hope over experience, and is somewhat analogous to giving the alcoholic the keys to the liquor store. Proponents of the idea naively assume that the addict is a normal person as long as he can obtain narcotics. They should talk to physician addicts who point out what a meaningless way of life this represents, and that their friends, their family, their profession, their accomplishments, all mean nothing to them. They are merely preoccupied with another "shot" a few hours from now, and of maintaining a state of mild euphoria. Their judgment can be incredibly lacking. As an example, in delivering a baby, one addict in performing an episiot-

omy nonchalantly cut through into the rectum, and with no sense of remorse whatever and no serious attempt to repair the damage, merely remarked that he must have been a little heavy with the knife. In other words, as far as he was concerned, he was a normal individual at that moment. Another one, in making a house call, took off his coat and gave himself a shot of Demerol in the vein in the presence of the patient and family, and stated, "Well now, I've solved my problem. What's yours?"

Actually, narcotic clinics were tried in the early '20's in most of the major cities in this country, and were abandoned as crime increased instead of decreasing, and addiction actually increased. The fact the proponents seem to disregard is that with easy accessibility to narcotics an addict's tolerance increases and increases, and he still will want more than can be supplied, and will turn to the peddler eventually anyway. The experience of the physician addict himself should disprove the clinics theory, since the physician has had narcotics available to him and diverts his own supply or writes fictitious prescriptions as a rule for a long time before he is apprehended. In fact, it is unusual for a physician to abandon the habit before he is apprehended.

The physician addict may need psychiatric help, but it is seldom effective unless he is institutionalized where narcotics are unavailable to him. One must individualize, however, and I well remember when one physician addict was asked whether or not he had sought psychiatric help, and his explosively indignant answer of, "Hell, no!" so impressed the Board members that they felt he was a good risk for restoration. His subsequent good record justified their judgment. Unhappily also, for those who theorize that an individual is normal as long as he has narcotics, many physicians induce their wives to become addicted.

THE "ENGLISH SYSTEM"

The so-called English system which, in theory at least, allows complete control of dispensing narcotics to addicts to the judgment of the medical profession, is put forth as desirable in view of the reported low incidence of narcotic addiction in England. It should be pointed out, however, that the same laws apply in Canada, and the relative incidence of addiction there parallels that in the United States, whereas in Hong Kong, where the same laws also apply, the amount of addiction is astronomical.

It should also be noted that in England the group having the easiest access to narcotics, namely, doctors, nurses, technicians, and hospital personnel, who constitute less than 1 per cent of the population, constitute 33 per cent of the addicts. It is also of interest to note that the per capita consumption of narcotics in England is slightly higher than in the United States.

The situation is, presumably, evidence that the English are just by nature a law-abiding people, since there are sixteen times as many murders per capita in Chicago as in London, and the United States rate of alcoholism is four times that of the English, and the divorce rate ten times that of the English. The legal process in England is swift and sure, with no such paradoxes as the Chessman case. Differences in the population itself enter into the picture as well, since Negroes, Mexicans and Puerto Ricans, who constitute about 10 per cent of the population in the United States, constitute about 80 per cent of the addicts.

Law enforcement agencies have gotten away from the punitive approach to the narcotic peddler, to one of quarantine. In other words, the peddler is put in jail for life if need be, not particularly to punish him but to quarantine him so he cannot promote more addiction.

The end results of the Cahan and comparable decisions* have been to make the life of the peddler less hazardous, and the cost of heroin decrease; but it serves no useful purpose to castigate the Supreme Court as being political rather than judicial in nature. The remedy lies in legislation.

A classical example of the legal as against the practical approach was in a case heard by the California Board of Medical Examiners wherein the act was one of alleged moral turpitude and involved, among other things, giving liquor to a minor. The attitude of the Board was that in acts involving moral turpitude it should investigate the matter and take into consideration the circumstances, the intent, and all factors, and then make a decision based upon all these facts, assuming that in some instances there would be moral turpitude and in other instances there wouldn't.

The Supreme Court, to the astonishment of the Board, ruled that an act involving moral turpitude must be heinous under all circumstances and, in effect, allowed no flexibility. This threw out a previous specific decision which involved the alleged selling of narcotics to addicts. At the time of the hearing, the witnesses had disappeared, and the only accusation possible was that of failure to keep proper records. Naturally, no one should have his license revoked for a minor failure to keep proper records of narcotics. It seemed logical, however, as evidenced by the decision in this case—which incidentally stood for many years—that there would be a substantial difference between minor failure to keep records and a failure to account for

*Decisions involving strict interpretation of search and seizure laws as well as laws which prohibit keeping the identity of the informer secret.

many more narcotics in a few months' time than the average physician would prescribe in a lifetime of practice. It might still be circumstantial evidence, but as Thoreau has said, "finding a fish in the milk is the best evidence that someone put water in it." In any event, this case was specifically ruled as no longer applying, and that was that!

The upshot of the matter, however, was that it was easy to introduce and have passed legislation which specifically spelled out the fact that the Board of Medical Examiners could have the power to inquire into the surrounding circumstances in cases involving moral turpitude.

Not all cases are alike, even though the financial transactions may be identical. Naturally, the legal profession wishes to protect such freedoms as have been gained after hard fighting and are essentially to protect the innocent from harassment. There must, however, be circumstances in which different rules do apply and the promotion of narcotic addiction would certainly fall into this category, just as the rules are changed in cases in war-time involving treason and espionage.

The difference between peddlers promoting a habit which a man never loses, and which affects his entire life, would certainly justify different rules, just as there is a difference in the lifetime effect of removing a finger or a few ounces of flesh, and removing a man's testicles or a woman's ovaries, even though the amount of tissue might weigh about the same.

In fact, legislation has been introduced in California which would allow evidence in narcotic cases to be introduced, no matter how the evidence was obtained. While effective law enforcement may seem a blunt way of approaching the problem, it should be pointed out that during the war years, when there was complete control and inspection of ships entering and leaving our ports, addiction in this country was at a minimum.

One shouldn't quarrel too much with success. The approach of the problem of kindly encouragement, with removal of easy access to narcotics but with the club of outright revocation for violation, has proven highly successful.

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REFERENCES

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